

Strategic Planning FY 2020-22



Impacting Social Determinants of Health
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Impact 2020 Recap

Status and Results

- Deliver High Quality Care
- Grow to Serve and Compete
- Foster Fiscal Stewardship
- Invest in Resources
- Leverage Valuable Assets
- **Impact Social Determinants**
- Advocate for patients



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Impact 2020

Progress and Updates-Social Determinants of Health

Name	Status
Ensure continued access for uninsured patients	<ul style="list-style-type: none">• Director of Carelink hired 11/18• Monthly meetings with joint agenda settings established• Carelink membership stable at 31,500• # of Carelink members in Care Coordination 326• Understanding admission reasons, ambulatory visits to refine care coordination approach
CCDPH data to plan intervention to improve population health	In Progress

Impact 2020

Progress and Updates-Social Determinants of Health

Name	Status
Partner with other organizations to impact social determinants of health	<ul style="list-style-type: none">• Food as Medicine Greater Chicago Food Depository food trucks at 13 sites• Contract in process for nutritional support for at-risk CCH patients and CountyCare members with Independent Living Systems• Partnership established with Black Oaks, planning for 2019 underway• Completed housing 33 units for Housing Forward, 30 for Illinois Housing Development Authority (IHDA)• Training for care coordination for Coordinated Entry System and assessments• Securing 56 vouchers for Housing Authority for Cook County (HACC)• Outreach started on Flexible Housing Pool initiative
Develop Care Coordination	Developed, 200 care coordination team members in multiple sites

Additional Activities Linked to Social Determinants

Focus Area	Activities	Results
Linkages to Mental Health (MH)/Substance Use Disorder (SUD) Services	<ul style="list-style-type: none"> Specialized discharge planning for those with medical complications of Opioid Use Disorder (OUD) Access to outpatient services via Behavioral Health Access Line (BHAL) Warm hand-offs for those in pretrial area at 26th and California with MH/SUD 	<ul style="list-style-type: none"> 60 patients per month 500 to 600 BHAL referrals per month to ambulatory providers Approximately 80 referrals per month to MH and SUD providers
Access to care	<ul style="list-style-type: none"> Additional support for Patient Support Center through Chicago Lighthouse 	<ul style="list-style-type: none"> 277,279 primary and specialty care appointments were made in in 2018. (30,011 Chicago Lighthouse) Initiation of concierge services for patients
Social Support	<ul style="list-style-type: none"> Utility Assistance Expansion of Community Health Worker activities of linkages to community based organizations 	<ul style="list-style-type: none"> \$180,000 in grants, average grant size \$250 to \$500.

Additional Activities Underway

Focus Area	Activities	Results
Income/Economic Support	<ul style="list-style-type: none">Legal Aid Foundation support to resolve Health Harming Needs<ul style="list-style-type: none">Access to public benefitsApplication for SSI and SSDI	2018 Referrals 256 Public Benefits 44 Housing 36 Family Law 80 ADAPT 22 Disability Cases (SSI/SSDI)
Transit	<ul style="list-style-type: none">Rides for discharged patients, ED patients, ACHN and methadone	110,000 rides since 9/17 95% on time arrival 27.4 minutes for on-demand rides 8821 bus passes for methadone treatment

Social Determinants

Facilitators

- A funding stream to enable this work this includes system resources as well as grant funds
- Health System willingness to engage for non- traditional service/support
- Staff willing to tackle the complexities associated with this work
- Willing external and internal partners

Health Risk Screening



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Health Risk Screening

Identification

Screening for Social Determinants of Health

- ED, Inpatient Units, Ambulatory Centers, Bond Court

Referrals from staff, physicians, CountyCare

Data review -- claims, utilization information

Results

- 17,093 CountyCare members were screened during 2018

Health Risk Screening

Self-Reported Data

Question	Potential Risk	Question	Potential Risk Factor
Last PCP visit >1 yr	(5%)	Abuse history	(3%)
Lack of transportation for medical appts	(20%)	Afraid of family member	(.6%)
Problems obtaining or paying for meds	(9%)	No one to help you for a few days	(26%)
Overall health	Fair (22.6) Poor (8.6%)	Need help getting food	(18%)
Presence of MH condition	(17.1%)	Help with housing	(10.9%)
Presence of SUD	(2.9%)	Help with utilities	(15.3%)
Unstable Living Situation	(2.0%)	Help with clothing	(12.1%)



Health Risk Screening

Frequency of Risk Indicators

	1-3 Indictors %	4-6 Indicators %	7 or more Indicators %	Population Size
Chronic MH	43.3 %	39.7%	16.8%	2,446
Chronic SUD	26.4%	43.0%	30.4%	702
MH/SUD	16.0%	40.8%	43.0%	411
Total Population	80.4%	16.0%	3.5%	17,093

FY2020-2022



Opportunities



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Impact Social Determinants/Advocate for Patients FY 2020-2022 Strategic Planning Recommendations

2018 Opportunities

- External partnerships are only partially defined; not clear how well they work/support the patients or members
- Engagement of physicians and medical home team members regarding CCH capabilities
- Being able to evaluate what really works for whom

Impact Social Determinants/Advocate for Patients FY 2020-2022 Strategic Planning Recommendations

Integrated Care Short-Term Plans

- Meet or exceed targets for all funded projects related to housing, opioid abuse, linkages to treatment for SMI
- Secure ongoing funding for MH/SUD activities when grant funding expires e.g. recovery coaches, AOT Assisted Outpatient Treatment (AOT) program, etc.
- Catalog existing activities regarding tobacco cessation, nutritional support, exercise and risk reduction for scalability and ease of referrals
- Identify top 3 social/community needs of CCH supported patients and identify strategy(ies) to meet needs
- Partner with CCDPH on one mutual project (housing for children at risk)
- Develop an understanding of patient approach and related successful interventions
- Develop and present a housing model for CCH patients

Impact Social Determinants/Advocate for Patients FY 2020-2022 Strategic Planning Recommendations

Organizing for Impact and Sustainability

- Create a coordinating committee -- success will depend on cross-department collaboration and coordination
- Identify working definitions for social determinants of health, which ones may be in the purview of CCH departments and strategies for others that may have significant impact
 - Complete gap analysis and provide recommendations
 - Document resource requirements, training etc.
 - Enter into discussions to support collaboration
- Review information from cataloging existing programs and determine next steps
- Complete implementation of social service data base

Thank You



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